Montgomery County 2005 Group Insurance Election Form - Retired Employees

PLEASE DO NOT FOLD OR STAPLE THIS FORM

MARKING INSTRUCTIONS

USE NO. 2 PENCIL ONLY

- Use a No. Pencil only.
- Do not use ink, ballpoint, or felt tip pens.
- Make solid marks that fill the response completely.
- Erase cleanly any marks you wish to change.
- Make no stray marks on this form.

CORRECT: ● INCORRECT: ✓ ✗ ◒ ◉

Your Social Security Number

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

Name:
Address:

OHR ID No.

Part A: YOUR CURRENT BENEFITS This will be your default coverage for 2005. Basic Life Insurance if eligible, is automatic. For your Medical, RX, Dental, and Vision elections, your coverage level will be determined by the number of dependents you enroll under the "**2005 Dependent Coverage Elections**" section in **Part G.**

	MEDICAL	PRESCRIPTION (RX)	DENTAL	VISION
Plan				
Coverage Level				

Optional Life
Dependent Life
Your Cost Share
Expiration date of County Cost Share

○ **FOR 2005 I WANT TO KEEP MY CURRENT BENEFITS AND CURRENT DEPENDENT COVERAGE ELECTIONS.**
If you elect this option, you can skip to the signature section in **Part H** in order to participate in 2005.
Electing this option will override changes made in Parts B, C, D, E, F and G of this Form.

Part B: MEDICAL & PRESCRIPTION (RX) COVERAGE (Choose one)

○ **MAINTAIN CURRENT MEDICAL AND RX COVERAGE** (Includes maintaining Identity Plan)

1. CAREFIRST POS PLAN (CURRENT "HIGH OPTION" PLAN)
- ○ Medical Only
- ○ Medical with High Option $4/$8 RX Plan

For eligible participants only living outside the POS service area.
- ○ Out of Area Medical Only
- ○ Out of Area Medical with High Option $4/$8 RX Plan

2. NEW CAREFIRST "STANDARD OPTION" POS PLAN
- ○ Medical Only
- ○ Medical with Standard Option $10/$20/$35 RX Plan

For eligible participants only living outside the POS service area.
- ○ Out of Area Medical Only
- ○ Out of Area Medical with Standard $10/$20/$35 RX Plan

3. KAISER HMO (INCLUDES KAISER RX PLAN)
- ○ Medical (Includes Kaiser RX Plan)
- ○ Medical (Includes Kaiser RX Plan) Plus add'l High Option $4/$8 RX Plan

4. OPTIMUM CHOICE HMO
- ○ Medical Only
- ○ Medical with High Option $4/$8 RX Plan

5. NO COVERAGE OPTIONS
- ○ No Medical; No RX
- ○ High Option $4/$8 RX Plan only, No Medical

Part C: DENTAL PLAN (Choose one)
- ○ Maintain Current Dental Coverage
- ○ Dental PPO (Traditional Dental Plan)
- ○ No Dental Coverage (Two year waiting period to re-enroll)

Part D: VISION PLAN (Choose one)
- ○ Maintain Current Vision Coverage
- ○ Discount Vision Plan
- ○ No Vision Coverage (Two year waiting period to re-enroll)

Part E: OPTIONAL LIFE (Choose one) (Optional Life Coverage ends at age 70)

- ◯ Maintain Current Coverage
- ◯ No Optional Life Coverage

Part F: DEPENDENT LIFE (Choose one)

- ◯ Maintain Current Coverage
- ◯ No Dependent Life Coverage

Part G: 2005 DEPENDENT COVERAGE ELECTIONS

You are automatically enrolled in the benefit plans elected above. For each dependent listed below, choose the plans under which you want them to be covered. The number of dependents you cover under each plan, will determine your coverage level, i.e, Self, Self + 1, Family, and your cost for that plan. To enroll a dependent in a plan, you must have elected the coverage for yourself above. **If you wish to add or delete dependents, you must complete a dependent Addition/Deletion form and submit to OHR along with the required documentation and this election form.**

	MEDICAL		PRESCRIPTION (RX)		DENTAL		VISION	
	Current	2005	Current	2005	Current	2005	Current	2005
1.		Y N		Y N		Y N		Y N
2.		Y N		Y N		Y N		Y N
3.		Y N		Y N		Y N		Y N
4.		Y N		Y N		Y N		Y N
5.		Y N		Y N		Y N		Y N
6.		Y N		Y N		Y N		Y N
7.		Y N		Y N		Y N		Y N
8.		Y N		Y N		Y N		Y N
9.		Y N		Y N		Y N		Y N
10		Y N		Y N		Y N		Y N

Do not add or delete dependents on this form.

Part H: SIGNATURE (Must be signed for elections to become effective)

I have read the materials for the County's group insurance programs, as well as the information available on the individual benefit plans. This election form indicates my benefit elections and dependent coverage for calendar year 2005 and authorizes the County to make the necessary deductions to my pay based on these elections. If I have elected no coverage for medical, prescription, dental, and vision, I understand that it is important that I have such coverage elsewhere that is adequate to meet my needs and the needs of my dependents. In order to protect the tax exempt status of the group insurance program. I understand that these elections are in effect for the entire 2005 calendar year and can only be changed during the year if I have a Change in Status, as allowed under Section 125 of the Internal Revenue Code and described in the Summary Plan Description for the group insurance program. I also understand that the County has a right to adjust my benefit elections to comply with the requirements of the Internal Revenue Code. I authorize the release of information contained of this election form to entities such as benefit carries, to the extent necessary to properly administer the benefits I have elected. I understand that electing benefits to which I, my dependents, or any other person are not entitled is considered fraud. In all cases I am responsible for my benefit elections and those of other persons for whom I elect to be covered. I further understand that if I willfully misrepresent my eligibility or that of any other person on this election form, or fail to take the steps necessary to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be cancelled, I may be required to repay any claims which have been paid inappropriately, and I may face charges or dismissal from County service. I understand that the County expects to continue the group insurance program, but it is the County's position that there is no implied contract between employees and the county to do so. I also understand that the County reserves the right at any time and for any lawfull reason to amend the program, subject to the County's collective bargaining agreements, where applicable. Further, I understand that the program may also be amended by the County at any time, either prospectively or retroactively, to confirm with the Internal Revenue Code.

Signature:_____ Date: _____

All forms must be signed and received in the Office of Humman Resourses, EOB 7th floor, 101 Monroe Street, Rockville, MD 20850, no later than **5:00 p.m., Wednesday, November 10, 2004.**

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